REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

File Number: _____

You have the right to request the Department of Health Services (DHS) to restrict the use and disclosure of the Cancer Detection Section information in its activities related to treatment, payment or operations. You also have the right to request that DHS not disclose Cancer Detection Section information to a family member, relative, or friend involved with the care or payment of the individual's health care. DHS may not be able to agree with your request. This form must be accompanied by a photocopy of a form of identification and documentation of your address. Mail this completed form to:

Cancer Detection Section
Attention: HIPAA Manger
MS-7203, P.O. Box 997413
Sacramento, CA 95899-7413

INDIVIDUAL FOR WHOM YOU ARE REQUESTING TO RESTRICT THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
Cancer Detection Programs: Every Woman Counts RECIPIENT ID NUMBER* _____	DATE OF BIRTH: _____	SOCIAL SECURITY NUMBER* _____
*We use these numbers to make sure that information access can be restricted only by authorized persons. If you don't supply at least one of the numbers, we will be unable to honor your request. You can get your Recipient ID Number from the place where you received medical services paid for by the Cancer Detection Programs: Every Woman Counts.		

PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:

DAYTIME PHONE NUMBER	ALTERNATE PHONE NUMBER	BEST TIME TO REACH YOU	EMAIL ADDRESS
( ) _____	( ) _____		

WHAT LEGAL AUTHORITY DO YOU HAVE TO RESTRICT THE HEALTH INFORMATION OF THE INDIVIDUAL ABOVE?

☐ PARENT ☐ CONSERVATOR

☐ GUARDIAN ☐ EXECUTOR OF WILL

☐ MEDICAL POWER OF ATTORNEY ☐ OTHER

PLEASE ATTACH LEGAL DOCUMENTATION VERIFYING THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL. EXECUTORS MUST ATTACH A DEATH CERTIFICATE.

CHECK ALL THAT APPLY

☐ **I REQUEST THAT THE DEPARTMENT OF HEALTH SERVICES RESTRICT THE USE AND DISCLOSURE OF THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION IN CARRYING OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS AS FOLLOWS:**

☐ **I REQUEST THAT DEPARTMENT OF HEALTH SERVICES RESTRICT THE DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE FOLLOWING PERSONS:**

IN THE SPACE ABOVE PLEASE PROVIDE THE NAMES OF ANY FAMILY MEMBERS, RELATIVES OR OTHERS TO WHOM YOU DO NOT WANT DHS TO DISCLOSE INFORMATION.

IDENTIFYING INFORMATION

☐ COPY OF PHOTO IDENTIFICATION ATTACHED

ACCEPTABLE IDENTIFICATION IS A CALIFORNIA DRIVER'S LICENSE, CALIFORNIA DMV IDENTIFICATION CARD, PASSPORT, MATRICULA CONSULAR OR STATE OR FEDERAL EMPLOYEE ID CARD.

I UNDERSTAND THE DEPARTMENT OF HEALTH SERVICES MAY NOT AGREE TO REQUESTED RESTRICTION(S), BUT WILL NOTIFY ME OF ITS RESPONSE TO MY REQUEST.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

REPRESENTATIVE SIGNATURE: DATE:

☐ **IF NO PHOTO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.**

NOTARIZED BY _____ ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

☐ IF THE PHOTO IDENTIFICATION DOESN'T SHOW THE ADDRESS ON PAGE 2 OF THIS FORM, PLEASE PROVIDE A PHOTOCOPY OF ONE OF THE FOLLOWING TO CONFIRM YOUR PRESENT ADDRESS: UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.

DHS is committed to protecting the information you provide us. To prevent unauthorized access or disclosure, to maintain data accuracy, and to ensure the appropriate use of the information, DHS has in place appropriate physical and managerial procedures to safeguard the information we collect.